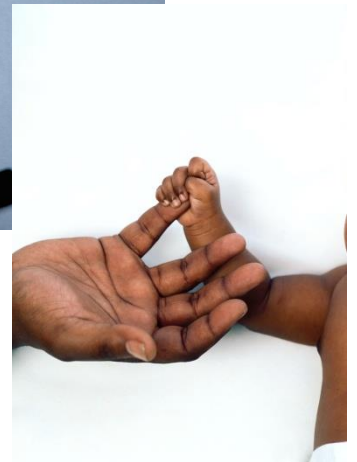
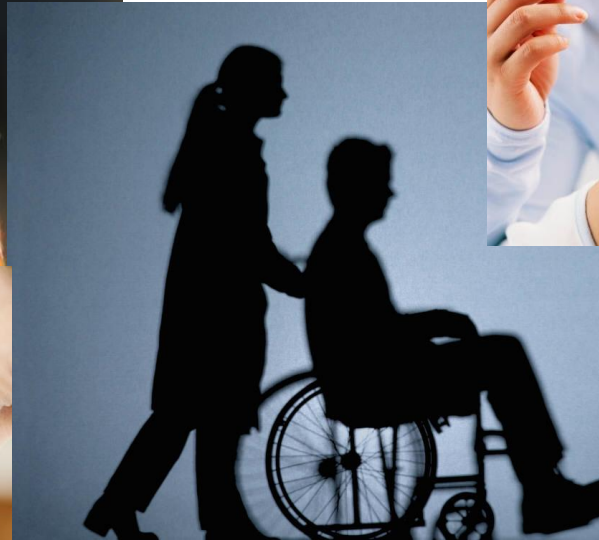


CITY OF STOCKTON



LEAVE BENEFITS

POLICY AND PROCEDURE MANUAL

**Effective August 2009
Updated July 2015**

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Purpose

Family and Medical Leave Act (FMLA), California Family Rights Act (CFRA), and Pregnancy Disability Leave (PDL) are intended to allow employees to balance their work and family life by taking reasonable leave for specific purposes listed in the policy. State Disability Insurance (SDI) is intended to provide partial wage-replacement to employees unable to work due to a non-work related illness or injury, pregnancy, or childbirth (available to specific union members only – See Memorandum of Understanding for specific information).

Policy

It is the administrative policy of the City of Stockton (“City”) to provide family and medical leave for eligible employees, as required by state and federal law, so employees are not required to choose between continuing employment and or attending to the needs of seriously ill family members or their own medical needs. Toward that end, an eligible employee is entitled to be restored to the same or an equivalent position upon return from FMLA and CFRA, or the same position upon return from PDL leave.

This policy sets forth rights and obligations with respect to such leave, in accordance with the Family and Medical Leave Act of 1993 (FMLA) and the California Family Rights Act (CFRA).

This policy will be administered by the Human Resources (HR) Department; although each department head, or designated person in each department, will ensure that the procedures set forth in this policy are followed.

The Human Resources Department will periodically schedule training classes on the guidelines and procedures set forth in this policy. This class will be mandatory for supervisors, and employees who have been assigned payroll functions

Definitions

12-month period

A rolling 12-month period, measured backwards from the first day an employee’s FMLA begins.

Active Duty (Covered)

On active duty or has been notified of an impending call or order to active duty in support of a contingency operation and requires deployment to a foreign country.

Continuing Treatment

A Serious Health Condition involving continuing treatment by a Health Care Provider includes any one or more of the following:

1. A period of incapacity (i.e., inability to work or to perform other regular daily activities due to the Serious Health Condition) of more than three consecutive full calendar

days, and any subsequent treatment or period of incapacity relating to the same condition that also involves:

- A. Treatment two or more times by a Health Care Provider, by a nurse or physician's assistant under direct supervision of a Health Care Provider, or by a provider of health care services (e.g., physical therapist) under orders of, or on referral by, a Health Care Provider within 30 days of the period of incapacity; or
 - B. Treatment by a Health Care Provider on at least one occasion that results in a regimen of continuing treatment under the supervision of the Health Care Provider.
- 2. Any period of incapacity due to pregnancy, or for prenatal care.
 - 3. Any period of incapacity or treatment for such incapacity due to a chronic Serious Health Condition. A chronic Serious Health Condition is one that:
 - A. Requires periodic visits (at least two visits to a healthcare provider per year) for treatment by a Health Care Provider, or by a nurse or physician's assistant under direct supervision of a Health Care Provider;
 - B. Continues over an extended period of time (including recurring episodes of a single underlying condition); and
 - C. May cause episodic rather than a continuing period of incapacity (e.g., asthma, diabetes, epilepsy, etc.)
 - 4. A period of incapacity that is permanent or long-term due to a condition for which treatment may not be effective. The employee or family member must be under the continuing supervision of, but need not be receiving active treatment by, a health care provider. (Examples include Alzheimer's Disease, a severe stroke, or the terminal stages of a disease.)
 - 5. Any period of absence to receive multiple treatments (including any recovery period) by a Health Care Provider or by a provider of health care services under orders of, or on referral by, a Health Care Provider, either for restorative surgery after an accident or other injury, or for a condition that would likely result in a period of incapacity of more than three consecutive calendar days in the absence of medical intervention or treatment, such as cancer, severe arthritis, or kidney disease. (Note: Any period of incapacity that results from pregnancy or a chronic condition is a qualifying event under this policy even if the employee does not receive treatment from a Health Care Provider or the absence does not last more than three (3) days.)

Eligible Employee

An employee who (1) has been employed for a total of 12 months by the City at any time prior to the commencement of FMLA/CFRA leave, including paid and unpaid leave; AND (2) has actually worked for the City at least 1,250 hours during the previous 12-month period, on

the date on which any FMLA leave is to commence; and (3) who meets all of the other requirements set forth in applicable law (see guidelines for eligibility requirements).

If an employee is not eligible for CFRA leave at the start of leave because the employee has not met the 12-month length of service requirement, the employee may become eligible while on leave, as this time counts towards the length of service requirement (although not for the 1,250 hour requirement).

Employment Benefits

Leave under federal and state mandates are unpaid, however, employees will be required to use accrued leave in most situations. While on family and medical care leave, all benefits provided or made available to eligible City employees will continue for up to 12 weeks each leave year. In the event an employee is disabled by pregnancy and also uses leave under the CFRA, the City will maintain the employee's health benefits while the employee is disabled by pregnancy (up to four months) and during the employee's CFRA leave (up to 12 weeks). Employees will still be responsible for the employee's share of the premiums for health benefits.

Coverage on a plan may be dropped if the employee is more than 30 days late in making a premium payment. Employee contribution rates are subject to change while the employee is on leave.

If an employee fails to return to work after his/her leave benefit has been exhausted or expires, the City has the right to recover its share of health plan premiums for the entire leave period, unless the employee does not return because of the continuation, recurrence, or onset of a serious health condition of the employee or his/her family member which would entitle the employee to leave, or because of circumstances beyond the employee's control. The City shall have the right to recover premiums through deductions from any sums due to the City (e.g. unpaid wages, vacation pay, etc.).

If the employee is enrolled in a voluntary benefit product (e.g. cancer policy), and goes into a non-paid status, the employee will be required to make premium payments directly with the policy holder to maintain the policy.

Family Member

A spouse/registered domestic partner, son, daughter, or parent (not parents-in-law).

Family Relationships under Military Leave

Several new family relationship definitions have been added due to the incorporation of the military family leave provisions. They include "parent of a military member," "son or daughter of a military member," "next of kin of a military member," and "son or daughter on active duty or call to active duty status."

Effective October 28, 2009, eligible family members of a veteran may now take Military Caregiver Leave if the veteran has incurred injuries or illnesses in the line of duty, provided that the medical treatment occurs within five (5) years of the veteran's membership in the Armed Forces.

Health Care Provider

A Health Care Provider is any of the following:

1. A doctor of medicine or osteopathy who is authorized to practice medicine or surgery by the state in which the doctor practices.
2. A podiatrist, dentist, clinical psychologist, optometrist, or chiropractor (limited to treatment consisting of manual manipulation of the spine to correct a subluxation as demonstrated by X-ray to exist) authorized to practice under state law and performing within the scope of his or her practice as defined by state law; and
3. Nurse practitioners, nurse-midwives and clinical social workers who are authorized to practice under state law and who are performing within the scope of their practice as defined under state law; and;
4. Christian Science practitioners, as specified in the Family and Medical Leave Act.
5. Any Health Care Provider from whom an employer or a group health plan's benefits manager will accept certification of the existence of a Serious Health Condition to substantiate a claim for benefits.
6. A Health Care Provider, as defined above, who practices in a country other than the United States, who is licensed to practice in accordance with the laws and regulations of that country.

Intermittent Leave

Leave taken in separate periods of time due to a single illness or injury, rather than for one continuous period of time. Leave may include periods from one hour to several weeks.

Key Employees

Salaried employees who are among the City's highest paid 10%. Key employees are not excluded from coverage under the FMLA, although an employer is allowed to deny them restoration in certain situations.

Medical Leave

Leave for up to 12 workweeks in a rolling 12-month period because of an employee's own Serious Health Condition that makes the employee unable to work at all or unable to perform any one or more of the essential functions of the position.

Military Member

A current member of the Regular Armed Forces, National Guard, or Reserves.

Parent

The biological, foster, adoptive, step parent, or a legal guardian of an employee or an individual who stood loco parentis (in the place of a parent) to an employee when the employee was a child. This term does not include parents-in-law.

Prenatal Care

The employee who is the husband or wife of a pregnant spouse is entitled to FMLA leave to care for the pregnant spouse who has severe morning sickness or other prenatal complications and to accompany her to prenatal doctors' appointments. Such leave is not available to a non-spouse father of the child (e.g. boyfriend or fiancé.)

Qualifying Exigency

A non-medical activity that is directly related to the military member's active duty or call to active duty status.

Reasonable Leave

A Family and Medical Leave request is reasonable if it complies with the notice requirements herein.

Reduced Leave Schedule

A leave schedule that reduces the usual number of hours per week or hours per workday of an employee, normally from full-time to part-time.

Registered Domestic Partner

A partner, as defined by the California Family Code, Section 297, and the California Domestic Partner Rights and Responsibility Act of 2003 and registered with the Secretary of State. (e.g. Two persons of the same sex or two persons of the opposite sex if one or both are over the age of 62.)

Serious Health Condition

For purposes of FMLA, "Serious Health Condition" entitles an employee to FMLA leave for an illness, injury, impairment, or physical or mental condition that involves:

1. **Inpatient care:** A stay in a hospital, hospice, or residential medical care facility, including any period of incapacity (i.e., inability to work or to perform other regular daily activities due to the Serious Health Condition, treatment involved, or recovery time), or any subsequent treatment in connection with such inpatient care. A person is considered an "inpatient" when admitted, even if he/she is later discharged and does not remain overnight; or
2. **Continuing treatment** by a Health Care Provider: A period of incapacity of more than three (3) full consecutive calendar days and any subsequent treatment or period of incapacity relating to the same condition that also involves:
 - A. Treatment two or more times within 30 days of the first day of incapacity by a Health Care Provider; or
 - B. Treatment by a Health Care Provider on at least one occasion that result in a regimen of continuing treatment under the supervision of the Health Care Provider.
 - C. May cause episodic incapacity rather than a continuing period of incapacity.

3. **Pregnancy:** Any period of incapacity due to pregnancy or for prenatal care. (This condition qualifies for FMLA leave, but not CFRA leave. Under California law, an employee disabled by pregnancy is entitled to Pregnancy Disability Leave.)
4. Any period of **incapacity** or treatment due to **chronic Serious Health Condition**, which:
 - A. Requires periodic visits (at least two times/year) for treatment by a Health Care Provider;
 - B. Continues over an extended period of time (including recurring episodes of a single underlying condition);
 - C. May cause episodic rather than a continuing period of incapacity (e.g. asthma, diabetes, epilepsy, etc.)
5. **Substance abuse** may be a qualifying condition if leave is taken for treatment for substance abuse by a Health Care Provider or by a provider of health care services on referral by a Health Care Provider. Absence because of the employee's use of substances rather than for treatment does not qualify for leave under this policy.

Disputes relating to qualifying health conditions will be referred to the HR Department for resolution.

Servicemember (covered)

A current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness; or a covered veteran who is undergoing medical treatment, recuperation or therapy for a serious injury or illness.

Son or Daughter

A biological, adopted, foster child, a stepchild, a legal ward, or a child of a person standing in loco parentis (in place of a parent).

Spouse

A husband and wife as defined or recognized under the state law for purposes of marriage in the state where the employee resides, including same-sex marriage.

Spousal Exception

If a married couple both work for the City and are eligible for leave under this policy, they are only entitled to a combined total of 12 workweeks during any rolling 12-month period for the birth, adoption or foster care placement of a child.

For all other qualifying events, each partner is entitled up to the full 12-workweek leave under this policy.

Twelve Work Weeks

The equivalent of 12 of the employee's normally scheduled workweeks.

Veteran (Covered)

An individual who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible employee takes FMLA leave to care for the covered veteran.

Note: The period between enactment of the FY 2010 NDAA on October 28, 2009 and the effective date of the 2013 Final Rule (March 8, 2013) is excluded in the determination of the five-year period for covered veterans.

What is FMLA?

The Family and Medical Leave Act (FMLA) of 1993 is a Federal Benefit which allows eligible employees of a covered employer to take unpaid leave for up to a total of 12 workweeks in a rolling 12-month period for:

1. Birth of a child and to care for the newborn child;
2. Placement of a child with the employee for adoption or foster care;
3. Care for a family member (child, spouse/domestic partner, or parent) with a Serious Health Condition or;
4. A Serious Health Condition of the employee that makes him/her unable to perform the functions of his/her position.
5. Military Amendment: The National Defense Authorization Act of 2008, was signed into law on January 28, 2008, creating two new leave benefits under FMLA (not CFRA):
 - A. Call to Active Duty (12 weeks leave):
Available to an eligible employee who is the spouse, son, daughter, parent, or next of kin of a military servicemember who is on active duty in support of a contingency operation to a foreign country as a result of a qualifying exigency (e.g. child care, parental care).
 - B. Caregiver Leave (26 weeks leave):
Available to an eligible employee who is the spouse, son or daughter, parent, or next of kin of a military servicemember who is undergoing medical treatment, recuperation, or therapy for a serious injury or illness. This includes any serious injury or illness that existed before the beginning of the member's active duty and were aggravated by service in the line of duty on active duty in the Armed Forces.

An employee on FMLA is entitled to have health benefits maintained, and generally, the right to return to the same position or an equivalent position with equivalent pay.

What is CFRA?

The California Family Rights Act (CFRA) is the state's version of FMLA. The state benefit program runs concurrently with FMLA, unless it is due to pregnancy (see #4 below). Below are the differences between the two programs:

1. Benefits: FMLA requires an employer to maintain group health benefits (medical, vision, dental); CFRA requires an employer to maintain all group benefits (life, long-term disability, AD&D, and Employee Assistance Program (EAP)).
2. Covered Employer: FMLA is required for all employers who employs 50 or more employees. CFRA extends to all state, county, state, and cities regardless of number of employees.
3. Domestic Partners: Covered under CFRA (but not FMLA).
4. Pregnancy: CFRA excludes pregnancy related disability; however, a mother is eligible to take an additional 12 weeks of leave under CFRA after the birth for bonding (12 weeks FMLA and 12 weeks CFRA).
5. CFRA does not run concurrently with Pregnancy Disability Leave (PDL); FMLA does run concurrently with PDL.

What is PDL?

Pregnancy Disability Leave (PDL) provides leave for an employee who is disabled by pregnancy, childbirth, or a related medical condition. Pregnancy itself is not a qualifying event. In order to qualify, the employee must prove that she is disabled by pregnancy. The disability period includes doctor-ordered bed rest and recovery from childbirth.

Benefit period

PDL provides up to four months (88 working days based on a traditional 8-hour, 5-day workweek) of leave for an employee who is disabled by pregnancy. If the employee works less than full-time, the 4 months is calculated on a proportional basis.

Waiting period

There is no waiting period or length of service requirement for PDL eligibility.

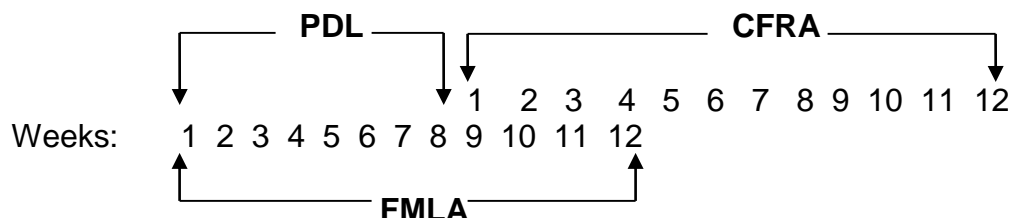
Disability period

The pregnant employee's Health Care Provider determines the length of the disability period. The leave does not need to be taken all at once. Intermittent leave could include morning sickness, as an example.

PDL runs concurrently with FMLA, but not CFRA

The sample below shows an employee disabled for two weeks prior to the birth of her child and six weeks after. The total of eight weeks will be both PDL and FMLA, running concurrently. She then chooses to take time off to bond with the newborn, which is CFRA

leave. The first four weeks will be FMLA and CFRA, as she has not exhausted all of her FMLA leave (FMLA covers both pregnancy disability-related absences as well as time taken for baby bonding). The remaining eight weeks will be CFRA only because FMLA has been exhausted.



What is SDI?

California State Disability Insurance (SDI) is a state program that provides partial wage-replacement insurance for California workers funded through employee payroll deductions. This is a wage-replacement program, not a leave benefit. Currently, only specific bargaining groups are eligible for this benefit based on their Memorandum of Understanding (MOU). Employees covered by SDI are eligible for two benefits:

1. **Disability Insurance:** Affordable, short-term benefits for employees who suffer a loss of wages when they are unable to work due to non-work-related illness or injury, or due to pregnancy or childbirth.
2. **Paid Family Leave:** Paid leave for employees who suffer a loss of wages when they need to take time off from work to care for a seriously ill child, spouse, parent, or registered domestic partner, parent-in-law, grandparent, grandchild, or sibling, or to bond with a new child.

This benefit is administered by the State of California Employment Development Department (EDD). Eligible employees can apply for this benefit by going to the EDD website. The City of Stockton will begin paying on the 8th day from the effective date listed on the claim form the HR or Payroll Department receive from EDD. This is based on a required 7-day waiting period. Employees have the option to use their annual leave or sick leave during the 7-day waiting period. The City will use the employees' leave banks to make paychecks 100% with partial EDD payments.

Eligibility Requirements

To be eligible for FMLA/CFRA benefits, an employee must:

1. Have been employed by the City for at least 12 months; and
2. Have worked a minimum of 1,250 hours within the 12-month period immediately preceding the commencement of the leave. The 1,250 hours include only those hours actually worked for the City. Paid leave (e.g. vacation/sick leave) and unpaid leave,

including FMLA leave, are not included in the 1,250 hours, but are included in the 12-month period.

Exempt employees, as defined in the Fair Labor Standards Act, are presumed to have worked 1,250 hours if they have worked for the City for at least 12 months.

When in dispute, all questions relating to eligibility of employees will be referred to the HR Department for resolution.

Amount of Leave

Leave may be taken on a continuous basis, intermittently, or on a reduced schedule, as is medically necessary.

Twelve Weeks

An eligible employee working full-time is entitled to up to twelve (12) workweeks (or sixty (60) workdays, or four hundred eighty (480) hours) of leave during a twelve-month period¹ when leave is taken for the following reasons:

1. Birth of an employee's child (Leave must be concluded within twelve (12) months of the birth of the child);
2. Placement of a child with an employee for adoption or foster care (Leave must be concluded within twelve (12) months of the placement of the child);
3. To care for a family member with a serious health condition;
4. The employee's own serious health condition; and
5. A qualifying exigency arising from an employee's family member being on active duty or called to active duty.

The twelve (12) month period for calculating this leave benefit is a "rolling" period measured backward from the date leave is taken. Each time an employee takes FMLA/CFRA leave, the remaining leave benefit will be any balance of twelve (12) workweeks which have not been used during the twelve (12)-month period.

When FMLA/CFRA leave is taken for the birth, adoption, or foster care placement of a child, the leave must be completed within one (1) year of the qualifying event. Additionally, the basic minimum duration of such leave is two (2) weeks, with the exception that on any two (2) occasions the Human Resources Director or designee may grant a request for FMLA/CFRA leave of less than two (2) weeks duration. Time off requests must follow City leave request guidelines.

A leave of twelve (12) weeks is provided to either parent for birth, adoption, or foster care placement of a child. However, FMLA/CFRA limits the total aggregate number of workweeks of leave to which a husband and wife are both entitled, if they work for the same employer, to

¹ The length of leave for part-time regular employees is pro-rated according to the number of hours worked per week.

a total of twelve (12) workweeks (combined between the two parents). In other words, married parents who both work for the City are only entitled to take twelve (12) weeks of leave under FMLA/CFRA. The limitation does not apply to unmarried parents. Parents may be on leave simultaneously.

Twenty Six Weeks

An eligible employee is entitled to up to twenty-six (26) workweeks of military caregiver leave during a single twelve (12) month period. The twelve (12) month period begins on the first day the employee takes leave and ends twelve (12) months after that date.

Unlike other types of family medical leave, military caregiver leave is a one-time benefit only; it does not renew annually. This leave benefit does not increase the amount of leave an employee may take for other FMLA/CFRA qualifying reasons during the single 12-month period. For example, an employee may combine military caregiver leave with other types of family medical leave during a single 12-month period. However, the employee is limited to taking a maximum of twenty-six (26) weeks of leave in such circumstances.

Fifteen Days

When applicable, an eligible family member may take the qualifying exigency leave up to a maximum of fifteen (15) days to match a military member's Rest and Recuperation leave orders.

Holiday

For purposes of determining the amount of leave used by an employee, the fact that a holiday may occur within a week taken as leave under this policy has no effect. The week is counted as a week of FMLA leave. However, when a holiday falls during a week when an employee is taking less than the full week of FMLA leave, the holiday is not counted as FMLA leave, unless the employee was scheduled and expected to work on the holiday and used FMLA leave for that day.

Employees who work more or less than a 5-day work week, or who work an alternative work schedule, receive leave on a pro-rated or proportional basis of 12 weeks.

Example: If an employee works five, 8-hour days every week, 12 workweeks equates to 60 working days of leave benefit. For an employee who works half-time, 12 workweeks will equate to 30-working days. In other words, 12 workweeks is defined by the employee's normal work schedule.

Required Use of Paid Accrued Leaves

FMLA/CFRA leave is an unpaid leave benefit. However, FMLA/CFRA guidelines authorize an employer to require that employees use paid accrued leaves while on family and medical leave prior to going into an unpaid status. If the employee is in a paid status due to a Short or Long Term Disability (STD/LTD), the employee is not in an "unpaid status", therefore, is not required to use accrued leave banks to supplement his/her income. However, if the employee does not have a City paycheck, certain deductions (such as the employee health contribution) will still be required. The employee will need to make arrangements, prior to leave (if possible), for these payments. The City will authorize the following:

Sick Leave: The employee's sick leave bank will be used first if the employee is using FMLA leave for his/her own Serious Health Condition or a family member's Serious Health Condition. If the employee's sick leave bank is exhausted and he/she is still on FMLA leave, they will be required to use their annual leave.

Exception: If the employee is using FMLA due to her own pregnancy disability, the employee is not required to use accrued annual leave, but can request to do so, per state regulations.

Annual Leave: The employee's annual leave bank will be used first if the employee is using FMLA for non-health related leaves (e.g. baby bonding). An employee who exhausts his/her annual leave bank may request to use their sick leave bank, but is not required to do so.

Compensatory Leave: The employee may use compensatory time for either health-related or non-health related FMLA leave.

FMLA leave will run concurrently with absences from work due to occupational injury and/or disability leave absences. The FMLA leave will be applied from the first day the employee is not at work. The only exception is for peace officers and firefighters who are on leave pursuant to Labor Code Section 4850.

If an employee is at his/her vacation maximum accrual cap, at the department head's discretion, the employee may utilize vacation hours prior to sick leave hours for caring for self or a family member with a serious health condition.

Please see Attachment #9, ***FMLA/CFRA HTE Payroll Codes***, to code employee timesheets correctly.

Employee Procedures

Planned (Foreseeable) Absence

The employee must provide the City **at least 30-days advance notice** before FMLA leave is to begin, if the need for leave is foreseeable based on the expected birth, placement for adoption or foster care of a child, or the planned medical treatment for a Serious Health Condition for you or a family member.

If 30-days notice is not practicable, notice must be given “**as soon as practicable**”. (As soon as practicable means as soon as possible, taking into account all of the facts and circumstances in the individual case.) A verbal notification to your immediate supervisor should be given within one or two business days of when the need for leave becomes known to you; however, you must provide notice **no later than three (3) business days** after the commencement of leave.

Unplanned (Unforeseeable) Absence

If the need for leave is unforeseeable, such as in an emergency, you or a family member must contact your immediate supervisor as soon as practicable.

Whether the leave is to be continuous, intermittent, or on a reduced schedule basis, initial notice need only be given one time for the same condition; however, you may be required to periodically recertify your eligibility for FMLA/CFRA leave or periodically report on your intent to return to work and you must advise the City as soon as practicable if dates of scheduled leave change, are extended, or were initially unknown.

1. **Notice**

If you want to invoke your rights under FMLA/CFRA, you should complete the ***City of Stockton Leave Request Form*** (Attachment #1) and provide to your immediate supervisor. **Failure to provide timely notice may delay absence from being coded as FMLA leave.**

2. **Determination of Eligibility**

The immediate supervisor will confirm if you are eligible or not eligible for FMLA/CFRA leave benefit. The supervisor will provide this information to you on the ***Notice of Eligibility Form*** (Attachment #2). The supervisor will also provide you with the ***Employee Rights and Responsibilities*** document (Attachment #3).

3. **Designation Notice**

Based on the information you provide to your supervisor, the supervisor will complete and provide you with the ***Designation Notice*** (Attachment #4) which states detailed dates and other pertinent information related to your FMLA/CFRA leave. Please read this notice carefully, as it could require you to supply additional information (e.g. medical certification, return to work documentation).

4. Medical Certification

Employees who request leave for their own serious health condition or to care for a child, parent, registered domestic partner, or spouse who has a serious health condition must provide written certification from the healthcare provider of the individual requiring care.

- A. Should you request leave for your own Serious Health Condition, the certification must include a statement that the employee is unable to work at all or is unable to perform the essential functions of his/her position. The employee must have the healthcare provider complete the ***Certification of Health Care Provider for Employee's Serious Health Condition*** (Attachment #5).
- B. Should you request leave for a family member's Serious Health Condition, have the family member's healthcare provider complete the ***Certification of Health Care Provider for Family Member's Serious Health Condition*** (Attachment #6).

You must submit a complete and sufficient medical certification **within 15 days** of your request for FMLA leave.

- C. You may be required to periodically recertify your eligibility for FMLA/CFRA leave or periodically report on your intent to return to work.

5. Return to Work Certification

- A. If your FMLA leave was due to your own Serious Health Condition, you must present to your supervisor a return to work certificate from your Health Care Provider stating that you are able to resume work. An employee's return to work will be governed by applicable state and federal law, including the Americans with Disabilities Act (ADA), and the provisions of any applicable collective bargaining agreement.
- B. If you are off work in excess of 3 days, you must notify your immediate supervisor of your intent to return to work a minimum of five (5) days prior to returning to work.
- C. The City can seek a fitness-for-duty certification only with regard to the particular health condition that caused your need for FMLA leave.

Employer Procedures

1. Notice

Requests for family or medical leave will be initiated through the employee's immediate supervisor. If the employee makes a verbal request for FMLA, the supervisor will provide the employee with the ***City of Stockton Leave Request Form*** (Attachment #1).

- A. If the need for FMLA leave is foreseeable, the employee will provide notice to the supervisor **30 days prior to the commencement of the leave** using the ***City of Stockton Leave Request Form*** (Attachment #1). If the employee is not at work and unable to sign the form, the supervisor is authorized to write "unable to sign" on the employee signature line. Please note that an employee does not need to mention the term "FMLA" to be granted FMLA leave. However, the employee must provide sufficient information to the supervisor for the supervisor to reasonably determine whether FMLA leave may apply to the leave request. Calling in "sick" is not enough to trigger an FMLA request.
- B. If the need for FMLA is foreseeable, but 30 days advance notice is not practicable, the employee will provide notice **no later than three (3) business days** after the commencement of leave.
- C. If the need for leave is unforeseeable, such as in an emergency, the employee or a family member must contact the immediate supervisor as early as practicable.

2. Determination of Eligibility

- A. Upon receipt of a ***City of Stockton Leave Request Form*** (Attachment #1), the supervisor will determine if the employee meets the eligibility requirements as set forth within this policy (see "Eligibility Requirements").
- B. The supervisor will then complete the ***Notice of Eligibility Form*** (Attachment #2), plus provide the employee with their ***Employee Rights and Responsibilities*** document (Attachment #3) **within five (5) business days** from the employee's request. Please note that if the employee requests additional leave later in the same FMLA leave year for the same qualifying event, a new notice is not required unless their eligibility has changed.

3. Designation Notice

Once a supervisor has determined the employee's FMLA eligibility, the supervisor must provide the employee with the ***Designation Notice*** (Attachment #4) either designating the leave as FMLA-qualifying or not FMLA-qualifying. The form must be completed no later than **five (5) business days** after the employee gives notice of the need for leave. A copy of all FMLA documents must be given to the employee.

4. Medical Certification

- A. If the request for FMLA is for the employee's own Serious Health Condition, he/she must submit the ***Certification of Health Care Provider for Employee's Serious Health Condition Form*** (Attachment #5) within 15 days from the date the employee received the Notice of Eligibility for FMLA leave (or longer if the employee has made diligent, good faith efforts to obtain it without success). Leave can be denied if it is not submitted within 15 days. The employer has no obligation to notify the employee that the certificate has not been received.
- B. If the request for FMLA is for the employee's Family Member's Serious Health Condition, the employee must submit the ***Certification of Health Care Provider for Family Member's Serious Health Condition Form*** (Attachment #6) within 15 days of their request for FMLA leave.

If either certificate has been submitted and is not complete or sufficient, the supervisor must provide the employee with **seven (7) days** to correct or complete the form and provide a list of what information is still needed.

- C. Supervisors who have questions regarding the authenticity of the medical certification must contact the HR Department.
- D. Recertification can be required every six months in connection with an absence that has occurred for that medical condition. A recertification can be required for the following reasons:
 - 1. Extension to a leave is requested
 - 2. Circumstances described in the last certification has changed
 - 3. The employer receives information casting doubt on the employee's stated reason for an absence
 - 4. Continuing validity of the last certification received
- E. In addition, as a condition of restoring the employee whose leave was due to the employee's own serious health condition the employer can require a **fitness-for-duty certification** from the City's contracted Physician with regard to the particular health condition that necessitated the employee's need for medical leave. The fitness for duty certification is more than a simple statement releasing the employee to work. The employer can require the Health Care Provider to assess whether the employee has the ability to perform the essential functions of the job. Any such assessment must be based on a job description of essential job duties provided by the employer.

5. Payroll and Other Record Keeping

Upon approval of leave, the supervisor will ensure that the necessary payroll type code be noted for FMLA into the HTE Payroll Module for all time designated as FMLA (see ***FMLA Leave Benefit Payroll Codes*** - Attachment #9). To ensure accurate

record keeping of all FMLA leave used, it is imperative that only FMLA codes be used during an employee's FMLA leave.

Copies of employee notices of leave furnished to the employer under FMLA, copies of all general and specific written notices given to the employee as required under FMLA, any records or documents relating to medical certifications, re-certifications or medical histories of employees or employees' family members, created for FMLA, shall be maintained as confidential in the employee's medical records file.

6. Employee's Obligation to Report on Status

As stated in 4.D., the employer may require that an employee recertify his/her eligibility for FMLA/CFRA leave. In addition, the employer may require the employee to periodically report on his/her intent to return to work.

7. Return to Work Certification

- A. An employee, whose FMLA leave was due to his/her own Serious Health Condition, must present to his/her supervisor a certification from the Health Care Provider that he/she is able to resume work. An employee's return to work will be governed by applicable state and federal law, including the Americans with Disabilities Act (ADA), and the provisions of any applicable collective bargaining agreement.
- B. An employee must notify his/her immediate supervisor if the return to work date differs from the date submitted on the original paperwork.
- C. An employee must provide to his/her immediate supervisor the completed return to work certificate supplied by the Health Care Provider before he/she returns to work.
- D. The City can seek fitness-for-duty certification only with regard to the particular health condition that caused the employee's need for FMLA leave. The employee must authorize or consent to the release of protected health information pursuant to the evaluation, and the City's contracted physician will not supply any protected health information to the City. As provided under the Confidentiality of Medical Information Act, the City's contracted physician will provide the City with a description of the employee's functional limitations, if any, that may entitle the employee to leave from work for medical reasons or limit the employee's fitness to perform his or her present employment, provided that no statement of medical cause is included in the information disclosed.

8. Non-Return from Leave

- A. If the employee notifies the supervisor that he/she is not returning from leave under this policy, the employee will not have the right to reinstatement to the same or equivalent position, unless such right is exercised under the applicable

City regulation (e.g. Americans with Disabilities Act (ADA) accommodation), Civil Service Rules and Regulations, or bargaining unit agreement.

- B. The employee will be entitled to continuation of health benefits only to the extent required by the Consolidated Omnibus Budget Reconciliation Act ("COBRA").
- C. As stated in Section 825.311(b) in the Department of Labor Regulations on FMLA, if an employee gives unequivocal notice of intent not to return to work, the employer's obligations under FMLA to maintain health benefits (subject to COBRA requirements) and to restore the employee will cease.

Return to Work Rights

- 1. Except as provided herein, or in applicable law, an employee will be entitled to return to the same position held prior to taking leave, or to an equivalent position with equivalent benefits, pay, and other terms and conditions of employment. An employee is entitled to such return to work rights even if the employee has been replaced or his/her position has been restructured to accommodate the employee's absence.
- 2. The City may delay the employee's return to work if he/she fails to provide a return to work certificate, as required in this policy.

Reinstatement Rights

- 1. An employee will have no greater right to reinstatement or to other benefits and conditions of employment than if the employee had been continuously employed during the leave provided under this policy. For example, if an employee is laid off during the course of taking FMLA leave and employment is terminated, the City's responsibility to continue FMLA leave, maintain group health plan benefits, and reinstate the employee cease at the time the employee is laid off, provided the City has no continuing obligations under a collective bargaining agreement or otherwise.
- 2. If the employee is unable to perform an essential function of the position because of a physical or mental condition, including the continuation of a Serious Health Condition, the employee will have no right to reinstatement under this policy, but may be accommodated in accordance with the Americans with Disabilities Act (ADA), and the City's Disability Accommodation Policy, HR-35.
- 3. The City may deny reinstatement to salaried eligible employees ("key employees," as defined in applicable law) if such denial is necessary to prevent substantial and grievous economic injury to the operations of the City.

Accommodation in Alternative Position

If it is foreseeable that an employee needs intermittent leave or leave on a reduced leave schedule, the employer may require the employee to transfer temporarily to an available alternative position for which the employee is qualified and which better accommodates recurring periods of leave than does the employee's regular position. Transfer to an alternative position requires:

1. Altering an existing job to better accommodate the employee's need for intermittent or reduced leave.
2. Compliance with the collective bargaining agreement, and federal law and state law.
3. Equivalent pay and benefits. An alternative position for these purposes does not have to have equivalent duties. The City may increase the pay and benefits of an existing alternative position, so as to make them equivalent to the pay and benefits of the employee's regular job.

FMLA Military Leave

On January 16, 2009, FMLA was amended to include military family leave provisions. These provisions created two (2) forms of leave benefits for family members of military members:

1. Qualifying Exigencies (Call to Active Duty)

To assist military members' family members in managing their affairs while their spouse, registered domestic partner, child, or parent is on active duty. This leave allows up to 12 work weeks off for non-medical needs. The following is a list of accepted qualifying exigencies:

- A. Short-notice deployment (7 or less calendar days prior to the date of deployment)
- B. Military events and related activities
- C. Childcare and school activities (e.g. to arrange for alternative childcare, attend a meeting at school)
- D. Financial and legal arrangements (e.g. to prepare and execute powers of attorney, enroll for military health care)
- E. Counseling
- F. Rest and recuperation (up to 15 calendar days)
- G. Post-deployment activities (to attend ceremonies, briefings)

H. Additional activities agreed to by the employer and employee

I. To care for a military member's parent who is incapable of self-care

Effective October 28, 2009, President Obama extended exigency leave benefits to family members of any armed service member, not just reservists.

The City will require the employee to provide a copy of the military member's order or other military documentation showing the military member's call to active duty and expected dates of active duty service. If leave is for Rest and Recuperation (R&R), a copy of the military member's R&R orders, or other documentation issued by the military is required.

2. Caregiver Leave

An eligible employee who is the spouse, registered domestic partner, son, daughter, parent, or next of kin of a military member will be entitled to up to a total of 26 workweeks of leave during a rolling 12-month period to care for the military member.

The need for FMLA leave to care for a seriously injured or ill service member is the same whether a military member is a member of the Regular Armed Forces or a member of the National Guard or Reserves.

Covered veterans who are undergoing medical treatment, recuperation, or therapy for a serious injury or illness qualify as well.

The City will require the employee to obtain a certificate from the military member's Health Care Provider. The Health Care Provider does not have to be associated with Department of Defense, Veteran's Affairs, or TRICARE.

Confidentiality

All paperwork generated, including applications for leave under this policy, documents relating to return from leave, and the Health Care Provider certifications will be forwarded to the HR Department, which will keep such information in the employee's confidential medical file.

Any questions you may have that are not addressed in this policy must be directed to the HR Department.



Attachment #1
**CITY OF STOCKTON
LEAVE REQUEST FORM**

Employee Name: _____

Position: _____

Department: _____

Type of Leave Requested

Date and Time Requested

- | | |
|--|---|
| <input type="checkbox"/> Annual Leave | Date(s): _____ |
| <input type="checkbox"/> Bereavement | Time: # of days: _____ # of hours: _____ |
| <input type="checkbox"/> Compensatory (Comp) Time | |
| <input type="checkbox"/> Family Sick Leave (Less than 3 days) | |
| <input type="checkbox"/> Family Medical Leave (FMLA) / California Family Rights Act (CFRA) Check appropriate box: | |
| <input type="checkbox"/> Birth of child or to care for a newborn | <input type="checkbox"/> Baby bonding |
| <input type="checkbox"/> Placement of a child due to adoption or foster care | <input type="checkbox"/> Employee's serious health condition |
| <input type="checkbox"/> Military Leave (Circle one):
Qualifying exigency
Care for military member | <input type="checkbox"/> Serious health condition of (Circle one):
Child, parent, spouse or domestic partner |
| <input type="checkbox"/> Jury Duty | |
| <input type="checkbox"/> Leave without Pay (LWOP) | |
| <input type="checkbox"/> Military Leave | |
| <input type="checkbox"/> Pregnancy Disability Leave (in conjunction with FMLA/CFRA) | |
| <input type="checkbox"/> Sick Leave | |

Employee Signature: _____ Date: _____

Supervisors Signature: _____ Date: _____



Attachment #2

**City of Stockton
Notice of Eligibility and Rights & Responsibilities
Family and Medical Leave Act (FMLA) / California Family Rights Act (CFRA)**

DATE:

Employee:

Supervisor:

PART A – NOTICE OF ELIGIBILITY

On _____, you informed us that you needed leave starting _____ due to:

- ☐ The birth of a child, or placement of a child with you for adoption or foster care
- ☐ Your own serious health condition
- ☐ Need to care for your: ☐ spouse/registered domestic partner; ☐ child; ☐ parent due to serious health condition.
- ☐ A qualifying exigency due to your ☐ spouse; ☐ son or daughter; ☐ parent being on active duty or called to active duty status in support of a contingency operation in a foreign country as a member of the Regular Armed Forces, National Guard or Reserves.
- ☐ Caring for a covered servicemember with a serious injury or illness and you are the ☐ spouse/registered domestic partner; ☐ son or daughter; ☐ parent; ☐ next of kin of this military member.

This Notice is to inform you that you:

- ☐ Are eligible for FMLA/CFRA leave (See Part B below for Rights and Responsibilities)
- ☐ Are **not** eligible for FMLA/CFRA leave, because:
 - ☐ You have not met the FMLA's 12-month length of service requirement. As of the first date of requested leave, you will have worked approximately _____ month(s) towards this requirement.
 - ☐ You have not met the FMLA's 1,250-hours-worked requirement.
 - ☐ You have exhausted all of your FMLA/CFRA leave in the applicable 12-month period.

If you have any questions, contact your immediate supervisor or Human Resources.

PART B – RIGHTS AND RESPONSIBILITIES FOR TAKING FMLA LEAVE

As explained in Part A, you meet the eligibility requirements for taking FMLA/CFRA leave and still have FMLA/CFRA leave available in the applicable rolling 12-month period. **In order for us to determine whether your absence qualifies as FMLA/CFRA leave, you must return the following information to us by: _____.**

- ☐ A medical certification (completed by your health care provider) to support your request for FMLA/CFRA leave if your leave request is in excess of 3 days. (Please see attached form). Failure to provide a complete and sufficient medical certification 15 calendar days from the date of this notice may result in a denial of or delay in the processing of your FMLA/CFRA leave request.
- ☐ Sufficient documentation to establish the required relationship between you and your family member.
- ☐ Other information needed: _____
- ☐ No other information is needed

If your leave does qualify as FMLA/CFRA, you will have the following responsibilities:

- You will be required to use your available paid leave accruals (sick, vacation, compensatory time) during your FMLA/CFRA absences. This means that you will receive paid leave and the leave will also be considered protected FMLA leave and counted against your FMLA/CFRA leave benefit. (See FMLA Policy & Procedures, “Required Use of Paid Accruals”.)
- If your FMLA/CFRA leave is due to your own medical condition, and your leave request is for an excess of 3 days, you will be required to submit appropriate medical documentation from the appropriate health care provider before you can return to work.
- If you pay a portion of your health benefits or participate in the City’s Section 125 plan, these expenses will continue to be deducted directly from your paycheck. However, if you are in a leave without pay status while on FMLA/CFRA, you must make arrangements to continue to pay your premium payments. Please contact the Human Resources Office to make these arrangements.



If your leave does qualify as FMLA/CFRA leave you will have the following rights:

- You have a right under the FMLA/CFRA for up to 12 weeks of unpaid leave in a 12-month period. The 12-month period is measured forward from the date of your first FMLA/CFRA leave usage.
- Military Leave Only:
You have a right under the FMLA for up to 26 weeks of unpaid leave in a rolling 12-month period to care for a military member with a serious injury or illness. This rolling 12-month period commenced on _____.
- Your health benefits must be maintained during any period of FMLA unpaid leave. However, you will still be responsible for any premiums you would normally pay while working.
- Unless you are determined to be a “key employee”, you will be reinstated to the same or an equivalent job with the same pay, benefits, and terms and conditions of employment on your return from FMLA-protected leave. (If your leave extends beyond the end of your FMLA benefit, you do not have return rights under FMLA.)
- If you do not return to work following FMLA period for a reason other than: 1) the continuation, recurrence, or onset of a serious health condition which would entitle you to FMLA leave; 2) the continuation, recurrence, or onset of a military member’s serious injury or illness which would entitle you to FMLA leave; or 3) other circumstances beyond your control, you will be required to reimburse the City for any health expenses paid on your or your family member’s behalf.

Upon receipt of the information specified above, you will be inform, within 5 business days, whether your leave will be designated as FMLA/CFRA leave and count towards your FMLA/CFRA leave benefit. If you have any questions, please contact: Human Resources Department-Benefits Section at 937-8865 or 937-7325.

By signing below, I certify that the above noted employee has met the FMLA’s 12-month length of service requirement and has met the minimum 1,250-hours-worked requirement. I also certify that the above-noted employee has not exhausted all his/her FMLA/CFRA leave in the applicable 12-month period.

Supervisor Name and Title

Supervisor Signature

Date

cc: Human Resources—Benefits Section

Attachment #3

EMPLOYEE RIGHTS AND RESPONSIBILITIES UNDER THE FAMILY AND MEDICAL LEAVE ACT

Basic Leave Benefit

FMLA requires covered employers to provide up to 12 weeks of unpaid, job-protected leave to eligible employees for the following reasons:

- For incapacity due to pregnancy, prenatal medical care or child birth;
- To care for the employee's child after birth, or placement for adoption or foster care;
- To care for the employee's spouse, son/daughter, parent, with a serious health condition; or
- For a serious health condition that makes the employee unable to perform their job.

Military Family Leave Benefits

Eligible employees with a spouse, son, daughter, or parent on active duty or call to active duty status in the Regular Armed Forces, National Guard or Reserves in support of a contingency operation to a foreign country may use their 12-week leave benefit to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, caring for a parent who is incapable of self-care, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave benefit that permits eligible employees to take up to 26 weeks of leave to care for a military member during a single 12-month period. A military member is a current member of the Armed Forces, including a member of the National Guard or Reserves, who has a serious injury or illness incurred in the line of duty on active duty or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the military member medically unfit to perform his or her duties for which the military member is undergoing medical treatment, recuperation, or therapy; or is in outpatient status; or is on the temporary disability retired list. Covered veterans who are undergoing medical treatment, recuperation, or therapy for a serious injury or illness qualify as well.

Benefits and Protections

During FMLA leave, the employer must maintain the employee's health coverage under any "group health plan" on the same terms as if the employee had continued to work. Upon return from FMLA leave, most employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA leave cannot result in the loss of any employment benefit that accrued prior to the start of an employee's leave.



Eligibility Requirements

Employees are eligible if they have worked for a covered employer for at least one year, for 1,250 hours over the previous 12 months, and if at least 50 employees are employed by the employer within 75 miles.

Definition of Serious Health Condition

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care provider for a condition that either prevents the employee from performing the functions of the employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than 3 consecutive calendar days combined with at least two visits to a health care provider or one visit and a regimen of continuing treatment, or incapacity due to pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

Use of Leave

An employee does not need to use this leave benefit in one block. Leave can be taken intermittently or on a reduced leave schedule when medically necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

Substitution of Paid Leave for Unpaid Leave

Employees may choose or employers may require use of accrued paid leave while taking FMLA leave. In order to use paid leave for FMLA leave, employees must comply with the employer's normal paid leave policies.

Employee Responsibilities

Employees must provide 30 days advance notice of the need to take FMLA leave when the need is foreseeable. When 30 days notice is not possible, the employee must provide notice as soon as practicable and generally must comply with an employer's normal call-in procedures.

Employees must provide sufficient information for the employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care provider, or circumstances supporting the need for military family leave. Employees also must inform the employer if the requested leave is for a reason for which FMLA leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.



Employer Responsibilities

Covered employers must inform employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the employees' rights and responsibilities. If they are not eligible, the employer must provide a reason for the ineligibility.

Covered employers must inform employees if leave will be designated as FMLA-protected and the amount of leave counted against the employee's leave benefit. If the employer determines that the leave is not FMLA-protected, the employer must notify the employee.

Unlawful Acts by Employers

FMLA makes it unlawful for any employer to:

- Interfere with, restrain, or deny the exercise of any right provided under FMLA;
- Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

Enforcement

An employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered employers to post the text of this notice. Regulations 29 C.F.R. § 825.300(a) may require additional disclosures.



Attachment #4

**City of Stockton
Designation Notice
Family and Medical Leave Act**

Leave covered under the Family and Medical Leave Act (FMLA) must be designated as FMLA-protected and the City of Stockton must inform the employee of the amount of leave that is counted against the employee's FMLA leave benefit. In order to determine whether leave is covered under FMLA, the City will require that the leave be supported by a medical certificate.

DATE (Notice Sent):	
TO (Employee):	

On _____, you notified us of your need to take family medical leave. This is to inform you that:

☐ **Your FMLA leave request is approved and will be designated as FMLA leave.**

The FMLA requires that you notify us as soon as practicable if dates of scheduled leave change or are extended or were initially unknown. Based on the information you have provided to date, we are providing the following information about the amount of time that will be counted against your leave benefit:

- ☐ Provided there is no deviation from your anticipated leave schedule, the following number of hours, days, or weeks will be counted against your leave benefit:
_____.
- ☐ The leave you will need is currently unknown or unscheduled; therefore, it is not possible to provide the specific hours, days, or weeks that will be counted against your FMLA benefit at this time.
- ☐ You will be required to present a Return to Work Certificate to be restored to employment. If the certificate is not received timely, your return to work may be delayed until the certificate is provided.

Please be advised that you are required to use paid leave during your FMLA leave.



If you normally pay a portion of the premiums for your health insurance or other benefits, such as voluntary products under the Section 125 plan, these payments will continue during the period of FMLA leave. Arrangements for payment have been discussed with you and it is agreed that you will make premium payments as follows:_____

☐ **Additional information is needed to determine if your FMLA leave request can be approved.**

☐ The medical certification you provided is not complete or sufficient enough to determine whether the FMLA applies to your leave request. You must provide the following information no later than _____(provide at least 7 calendar days)

(Specify information needed to make the certification complete and sufficient).

☐ We are exercising our right to have you obtain a second (or third) opinion medical certification at our expense, and we will provide further details at a later time.

☐ **Your FMLA leave request is not approved because:**

☐ FMLA does not apply to your leave request

☐ You have exhausted your FMLA leave benefit for this rolling 12-month period

Supervisor Name:_____

Supervisor Signature:_____Date:_____

cc: Department Payroll
Human Resources-Benefits Section



Attachment #5

City of Stockton
Employee Health Care Provider's Certification Form

Section I: To be Completed by the Employee

INSTRUCTIONS TO THE EMPLOYEE: Please complete Section I before giving this form to your medical provider. FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to your own serious health condition. Failure to provide this medical certification within **15 calendar** days from the date you requested FMLA/CFRA, may result in a denial of or delay in the processing of your FMLA/CFRA request.

Employee's Name (First, Middle, Last) – Please print

Employee's Job Title

Section II: To be Completed by the Health Care Provider

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: Your patient has requested leave under the Family and Medical Leave Act (FMLA) / California Family Rights Act (CFRA) for a serious health condition. Please answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA/CFRA coverage. Limit your responses to the condition for which the employee is seeking leave.

1. Provider's name: (Please print)_____
2. Provider's address:_____
3. Provider's phone #: () _____ Fax #: () _____
4. Type of practice / Medical specialty: _____
6. License Number:_____

MEDICAL FACTS

1. Approximate date on which health condition began: _____
2. Probable duration of condition: _____
3. **The serious health condition to which you are treating the patient for.** (Please note that the following are **not** normally considered serious health conditions: Common cold or flu, upset stomach, headache-excluding migraines, earache, routine dental problem, or treatments that involve only over-the-counter medicines, bed rest, exercise, and other activities that can be done without visiting a health care provider):
 - ☐ Inpatient care during an overnight hospital stay, hospice, or residential health care facility; Date of Admission: _____
 - ☐ Prenatal care;
 - ☐ Pregnancy (leave taken for disability due to pregnancy, childbirth, or related medical conditions); Expected delivery date: _____
 - ☐ Chronic conditions (e.g., asthma, diabetes, epilepsy, etc.) that (1) require periodic visits (at least twice a year) for treatment, (2) continue for a long time, and (3) may cause episodic rather than a continuing period of incapacity;
 - ☐ Permanent or long-term conditions that require continuing supervision, with or without active treatment (such as Alzheimer's, severe strokes, terminal stages of a disease);
 - ☐ Multiple treatments for either (1) restorative surgery after an injury, or (2) conditions likely to result in three day's incapacity if not treated (including chemotherapy, physical therapy for severe arthritis, and dialysis); or

- ☐ Incapacity for more than three consecutive days during which the patient is either (1) treated two or more times, or (2) treated and referred to a nurse, physician's assistant, physical therapist, or nurse practitioner for further treatment; or (3) treated and prescribed a course of prescription medication or therapy requiring special equipment to resolve or alleviate the health condition;
- ☐ None of the above. Patient does not have a serious health condition as defined by the FMLA.

4. Date(s) you treated the patient for condition:

5. Was medication, other than over-the-counter medication, prescribed?

☐ Yes ☐ No

6. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)? ☐ Yes ☐ No

If "Yes", state the nature of such treatment and expected duration of treatment:

7. Based on the employee's description of his/her job functions, is the employee unable to perform any of his/her job functions due to the condition:

☐ Yes ☐ No. If "Yes", identify the job functions the employee is unable to perform:

5. Will the employee be incapacitated for a single continuous period of time due to his/her medical condition, including any time for treatment and recovery?



☐ Yes ☐ No

If "Yes", estimate the beginning and ending dates for the period of incapacity:

Complete the following ONLY if the employee requires intermittent leave or a reduced work schedule:

6. Will the employee require follow-up treatment appointments or be off work on an intermittent basis or on a reduced schedule because of his/her medical condition?

☐ Yes ☐ No

If "Yes", are the treatments or the reduced number of hours of work medically necessary?

☐ Yes ☐ No

Please estimate the intermittent leave or reduced work schedule the employee needs:

_____ hour(s) per day; _____ days per week

from _____ through _____

7. Will the condition cause episodic flare-ups preventing the employee from periodically performing his/her job functions?

☐ Yes ☐ No

Is it medically necessary for the employee to be absent from work during the flare-ups?

☐ Yes ☐ No

If "Yes", explain: _____

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s) and

Duration: _____ hours or _____ day(s) per episode

Health Care Provider's Signature: _____ Date: _____



Attachment #6

City of Stockton
Family Member's Health Care Provider's Certification Form

Section I: To be Completed by the Employee

INSTRUCTIONS TO THE EMPLOYEE: Please complete Section I before giving this form to your family member or his/her medical provider. FMLA permits an employer to require that you submit a timely, complete, and sufficient medical certification to support a request for FMLA leave due to care for a covered family member with a serious health condition. Failure to provide this medical certification within **15 calendar** days from the date you requested FMLA/CFRA, may result in a denial of or delay in the processing of your FMLA request.

Employee's Name (First, Middle, Last) – Please print

Name of family member for whom you will provide care (First, Middle, Last) – Please print

Relationship of family member to you: _____

If family member is your son or daughter, date of his/her birth: _____

Describe the care you will provide to your family member and the estimated amount of leave time needed to provide care: _____

Employee Signature

Date:

Section II: To be Completed by the Health Care Provider

INSTRUCTIONS TO THE HEALTH CARE PROVIDER: The employee listed above has requested leave under the Family and Medical Leave Act (FMLA) / California Family Rights Act (CFRA) to care for your patient. Please answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as "lifetime," "unknown," or "indeterminate" may not be sufficient to determine FMLA/CFRA coverage. Please be sure to sign the form on the last page.



1. Provider's name: (Please print) _____
2. Provider's address: _____
3. Provider's phone number: () _____ Fax number: () _____
4. Type of practice / Medical specialty: _____
5. License number: _____

MEDICAL FACTS

1. Approximate date on which health condition began: _____
2. Probable duration of condition: _____
3. **The serious health condition to which you are treating the patient for.** (Please note that the following are **not** normally considered serious health conditions: Common cold or flu, upset stomach, headache-excluding migraines, earache, routine dental problem, or treatments that involve only over-the-counter medicines, bed rest, exercise, and other activities that can be done without visiting a health care provider):
 - ☐ Inpatient care during an overnight stay in a hospital, hospice, or residential health care facility; or was the patient expected to have an overnight stay?
Date of Admission: _____
 - ☐ Prenatal care;
 - ☐ Pregnancy (leave taken for disability due to pregnancy, childbirth, or related medical conditions); Expected delivery date: _____
 - ☐ Chronic conditions (e.g., asthma, diabetes, epilepsy, etc.) that (1) require periodic visits (at least twice a year) for treatment, (2) continue for a long time, and (3) may cause episodic rather than a continuing period of incapacity;
 - ☐ Permanent or long-term conditions that require continuing supervision, with or without active treatment (such as Alzheimer's, severe strokes, terminal stages of a disease);
 - ☐ Multiple treatments for either (1) restorative surgery after an injury, or (2) conditions likely to result in three day's incapacity if not treated (including chemotherapy, physical therapy for severe arthritis, and dialysis);

- ☐ Incapacity for more than three consecutive days during which the patient is either (1) treated two or more times, or (2) treated and referred to a nurse, physician's assistant, physical therapist, or nurse practitioner for further treatment; or (3) treated and prescribed a course of prescription medication or therapy requiring special equipment to resolve or alleviate the health condition;
- ☐ None of the above categories apply. Patient does not have a serious health condition as defined by FMLA.

4. Date(s) you treated the patient for condition:

5. Was medication, other than over-the-counter medication, prescribed?

☐ Yes ☐ No

6. Was the patient referred to other health care provider(s) for evaluation or treatment (e.g. physical therapist)? ☐ Yes ☐ No

If "Yes", state the nature of such treatment and expected duration of treatment:

AMOUNT OF CARE NEEDED

7. Will the patient be incapacitated for a single continuous period of time, including any time for treatment and recovery?

☐ Yes ☐ No

If "Yes", estimate the beginning and ending dates for the period of incapacity: _____

8. Will the patient require follow-up treatments including any time for recovery?

☐ Yes ☐ No

9. Please estimate treatment schedule, if any, including the dates of any scheduled appointments and the time required for each appointment, including any recovery period:

During this time, will the patient need care? ☐ Yes ☐ No



If "Yes", explain the care needed by the patient and why it is medically necessary for the employee to take time off from work to provide this care: _____

Complete the following ONLY if employee requires intermittent leave or reduced schedule to care for your patient:

10. Will the patient require follow-up treatment appointments because of his/her medical condition? ☐ Yes ☐ No

If "Yes", please estimate the hours the patient needs care on an intermittent basis:

_____ Hour(s) per day; _____ days per week from _____ through _____

11. Will the condition cause episodic flare-ups preventing the patient from participating in normal daily activities?

☐ Yes ☐ No

Based upon the patient's medical history and your knowledge of the medical condition, estimate the frequency of flare-ups and the duration of related incapacity that the patient may have over the next 6 months (e.g., 1 episode every 3 months lasting 1-2 days):

Frequency: _____ times per _____ week(s) _____ month(s) and

Duration: _____ hours or _____ day(s) per episode

Does the patient require care during these flare-ups? ☐ Yes ☐ No

If "Yes", explain the care needed by the patient and why it is medically necessary for the employee to take time off from work to provide this care: _____

Health Care Provider's Signature: _____ Date: _____



Attachment #7

U.S. Department of Labor

Wage and Hour Division
OMB Control Number: 1235-0003
Expires: 2/28/15

**Certification of Qualifying Exigency
For Military Family Leave
(Family and Medical Leave Act)**

SECTION I: For Completion by the EMPLOYER

Instructions to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a qualifying exigency to submit a certification. Please complete Section I before giving this form to your employee. Your response is voluntary, and while you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 C.F.R. § 825.309.

Employer name: _____

Contact Information: _____

SECTION II: For Completion by the EMPLOYEE

Instructions to the EMPLOYEE: Please complete Section II fully and completely. The FMLA permits an employer to require that you submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a qualifying exigency. Several questions in this section seek a response as to the frequency or duration of the qualifying exigency. Be as specific as you can; terms such as “unknown” or “indeterminate” may not be sufficient to determine FMLA coverage. Your response is required to obtain a benefit. 29 CFR 825.310. While you are not required to provide this information, failure to do so may result in denial of your request for FMLA leave. Your employer must give you at least 15 calendar days to return this form to them.

Your Name: _____
First Middle Last

Name of military member on active duty or call to active duty in support of a contingency operation:

First Middle Last

Relationship of military member to you: _____

Period of military member's covered active duty: _____

A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes written documentation confirming a military member's active duty or call to covered active duty status in support of a contingency operation. Please check one of the following and attach the indicated document to support that the military member is on covered active duty or call to covered active duty status.

- ___ A copy of the military member's covered active duty orders is attached.
- ___ Other documentation from the military certifying that the military member is on covered active duty (or has been notified of an impending call to active duty) is attached.
- ___ I have previously provided my employer with sufficient written documentation confirming the military member's covered active duty or call to active duty status.



PART A: QUALIFYING REASON FOR LEAVE

1. Describe the reason you are requesting FMLA leave due to a qualifying exigency (including the specific reason you are requesting leave):

2. A complete and sufficient certification to support a request for FMLA leave due to a qualifying exigency includes any available written documentation which supports the need for leave; such documentation may include a copy of a meeting announcement for informational briefings sponsored by the military; a document confirming the military member's R&R leave; a document confirming an appointment with a third party, such as a counselor or school official, or staff at a care facility; or a copy of a bill for services for the handling of legal or financial affairs. Available written documentation supporting this request for leave is attached.
___ Yes ___ No ___ None Available

PART B: AMOUNT OF LEAVE NEEDED

1. Approximate date exigency commenced: _____
Probable duration of exigency: _____
2. Will you need to be absent from work for a single continuous period of time due to the qualifying exigency? ___ Yes ___ No
If so, estimate the beginning and ending dates for the period of absence:

3. Will you need to be absent from work periodically to address this qualifying exigency? ___ Yes ___ No
Estimate schedule of leave, including the dates of any scheduled meetings or appointments:

Estimate the frequency and duration of each appointment, meeting, or leave event, including any travel time (i.e., 1 deployment-related meeting every month lasting 4 hours):

Frequency: _____ times per _____ week(s) _____ month(s)
Duration: _____ hours ___ day(s) per event.



PART C:

If leave is requested to meet with a third party (such as to arrange for childcare or parental care, to attend meetings with school, childcare or parental care providers, to make financial or legal arrangements, to act as the military member's representative before a federal, state, or local agency for purposes of obtaining, arranging or appealing military service benefits, or to attend any event sponsored by the military or military service organizations), a complete and sufficient certification includes the name, address, and appropriate contact information of the individual or entity with whom you are meeting (i.e., either the telephone or fax number or email address of the individual or entity). This information may be used by your employer to verify that the information contained on this form is accurate.

Name of Individual: _____ Title: _____

Organization: _____

Address: _____

Telephone: (_____) _____ Fax: (_____) _____

Email: _____

Describe nature of meeting: _____

PART D:

I certify that the information I provided above is true and correct.

Signature of Employee

Date

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years. 29 U.S.C. 2616; 29 CFR 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE EMPLOYER.**



Attachment #8

Certification for Serious Injury or Illness of a Current Servicemember – For Military Family Leave (Family and Medical Leave Act)

U.S. Department of Labor

Wage and Hour Division

OMB Control Number: 1235-0003

Expires: 2/28/2015

Notice to the EMPLOYER

INSTRUCTIONS to the EMPLOYER: The Family and Medical Leave Act (FMLA) provides that an employer may require an employee seeking FMLA leave due to a serious injury or illness of a current servicemember to submit a certification providing sufficient facts to support the request for leave. Your response is voluntary. While you are not required to use this form, you may not ask the employee to provide more information than allowed under the FMLA regulations, 29 CFR 825.310. Employers must generally maintain records and documents relating to medical certifications, recertifications, or medical histories of employees or employees' family members created for FMLA purposes as confidential medical records in separate files/records from the usual personnel files and in accordance with 29 CFR 1630.14(c)(1), if the Americans with Disabilities Act applies.

SECTION I: For completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee is Requesting Leave.

Instructions to the EMPLOYEE or CURRENT SERVICEMEMBER: Please complete Section I before having Section II completed. The FMLA permits an employer to require that an employee submit a timely, complete, and sufficient certification to support a request for FMLA leave due to a serious injury or illness of a servicemember. If requested by the employer, your response is required to obtain or retain the benefit of FMLA-protected leave. 29 U.S.C. 2613, 2614(c)(3). Failure to do so may result in a denial of an employee's FMLA request. 29 CFR 825.310(f). The employer must give an employee at least 15 calendar days to return this form to the employer.

SECTION II: For completion by a UNITED STATES DEPARTMENT OF DEFENSE ("DOD") HEALTH CARE PROVIDER or a HEALTH CARE PROVIDER who is either: (1) a United States Department of Veterans Affairs ("VA") health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125

Instructions to the HEALTH CARE PROVIDER: The employee listed on Page 2 has requested leave under the FMLA to care for a family member who is a member of the Regular Armed Forces, the National Guard, or the Reserves who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list for a serious injury or illness. For purposes of FMLA leave, a serious injury or illness is one that was incurred in the line of duty on active duty in the Armed Forces or that existed before the beginning of the member's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform the duties of his or her office, grade, rank, or rating.

A complete and sufficient certification to support a request for FMLA leave due to a current servicemember's serious injury or illness includes written documentation confirming the servicemember's injury/illness was incurred in the line of duty on active duty or if not, that the current servicemember's injury or illness existed before the beginning of the servicemember's active duty and was aggravated by service in the line of duty on active duty in the Armed Forces, and that the current service member is undergoing treatment for such injury or illness by a health care provider listed above.



Answer, fully and completely, all applicable parts. Several questions seek a response as to the frequency or duration of a condition, treatment, etc. Your answer should be your best estimate based upon your medical knowledge, experience, and examination of the patient. Be as specific as you can; terms such as “lifetime,” “unknown,” or “indeterminate” may not be sufficient to determine FMLA coverage. Limit your responses to the servicemember’s condition for which the employee is seeking leave.

SECTION I: For completion by the EMPLOYEE and/or the CURRENT SERVICEMEMBER for whom the Employee is Requesting Leave:

(This section must be completed first before any of the below sections can be completed by a health care provider.)

Part A: EMPLOYEE INFORMATION

Name and Address of Employer (this is the employer of the employee requesting leave to care for current servicemember):

Name of Employee Requesting Leave to Care for Current Servicemember:

First

Middle

Last

Name of Current Servicemember (for whom employee is requesting leave to care):

First

Middle

Last

Relationship of Employee to Current Servicemember:

☐ Spouse ☐ Parent ☐ Son ☐ Daughter ☐ Next of Kin

Part B: SERVICEMEMBER INFORMATION

- (1) Is the Servicemember a Current Member of the Regular Armed Forces, the National Guard or Reserves?
_____ Yes _____ No

If yes, please provide the servicemember’s military branch, rank and unit currently assigned to:

Is the servicemember assigned to a military medical treatment facility as an outpatient or to a unit established for the purpose of providing command and control of the Armed Forces receiving medical care as outpatients (such as a medical hold or warrior transition unit)?

___ Yes ___ No

If yes, please provide the name of the medical treatment facility or unit:

- (2) Is the CServicemember on the Temporary Disability Retired List (TDRL)?
_____ Yes _____ No



Describe the Care to Be Provided to the Current Servicemember and an Estimate of the Leave Needed to Provide the Care:

SECTION II: For completion by a United States Department of Defense (“DOD”) Health Care Provider or a Health Care Provider who is either: (1) a United States Department of Veterans Affairs (“VA”) health care provider; (2) a DOD TRICARE network authorized private health care provider; (3) a DOD non-network TRICARE authorized private health care provider; or (4) a health care provider as defined in 29 CFR 825.125. If you are unable to make certain of the military-related determinations contained below in Part B, you are permitted to rely upon determinations from an authorized DOD representative (such as a DOD recovery care coordinator). (Please ensure that Section I above has been completed before completing this section. Please be sure to sign the form on the last page.)

Part A: HEALTH CARE PROVIDER INFORMATION

Health Care Provider’s Name and Business Address:

Type of Practice/Medical Specialty: _____

Please state whether you are either: (1) a DOD health care provider; (2) a VA health care provider; (3) a DOD TRICARE network authorized private health care provider; (4) a DOD non-network TRICARE authorized private health care provider; or (5) a health care provider as defined in 29 CFR 825.125:

Telephone: () _____ Fax: () _____ Email: _____

PART B: MEDICAL STATUS

(1) The Current Servicemember’s medical condition is classified as (Check One of the Appropriate Boxes):

☐ **(VSI) Very Seriously Ill/Injured** – Illness/Injury is of such a severity that life is imminently endangered. Family members are requested at bedside immediately. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.)

☐ **(SI) Seriously Ill/Injured** - Illness/Injury is of such severity that there is cause for immediate concern, but there is no imminent danger to life. Family members are requested at bedside. (Please note this is an internal DOD casualty assistance designation used by DOD healthcare providers.

☐ **OTHER Ill/Injured** – a serious injury or illness that may render the servicemember medically unfit to perform the duties of the member’s office, grade, rank, or rating.

☐ **NONE OF THE ABOVE** – (Note to Employee: If this box is checked, you may still be eligible to take leave to care for a covered family member with a “serious health condition” under § 825.113 of the FMLA. If such leave is requested, you may be required to complete DOL FORM WH-380 or an employer-provided form seeking the same information.)

(2) Is the current Servicemember being treated for a condition which was incurred or aggravated by service in the line of duty on active duty in the Armed Forces? ____ Yes ____ No



(3) Approximate date condition commenced: _____

(4) Probable duration of condition and/or need for care: _____

(5) Is the Servicemember undergoing medical treatment, recuperation, or therapy?
___ Yes ___ No

If yes, please describe medical treatment, recuperation or therapy:

PART C: COVERED SERVICEMEMBER'S NEED FOR CARE BY FAMILY MEMBER

(1) Will the servicemember need care for a single continuous period of time, including any time for treatment and recovery? ___ Yes ___ No

If yes, estimate the beginning and ending dates for this period of time: _____

(2) Will the servicemember require periodic follow-up treatment appointments? ___ Yes ___ No

If yes, estimate the treatment schedule: _____

(3) Is there a medical necessity for the servicemember to have periodic care for these follow-up treatment appointments? ___ Yes ___ No

(4) Is there a medical necessity for the servicemember to have periodic care for other than scheduled follow-up treatment appointments (e.g., episodic flare-ups or medical condition)?
___ Yes ___ No

If yes, please estimate the frequency and duration of the periodic care:

Signature of Health Care Provider: _____ **Date:** _____

PAPERWORK REDUCTION ACT NOTICE AND PUBLIC BURDEN STATEMENT

If submitted, it is mandatory for employers to retain a copy of this disclosure in their records for three years, in accordance with 29 U.S.C. 2616; 29 CFR 825.500. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number. The Department of Labor estimates that it will take an average of 20 minutes for respondents to complete this collection of information, including the time for reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection information, including suggestions for reducing this burden, send them to the Administrator, Wage and Hour Division, U.S. Department of Labor, Room S-3502, 200 Constitution AV, NW, Washington, DC 20210. **DO NOT SEND THE COMPLETED FORM TO THE WAGE AND HOUR DIVISION; RETURN IT TO THE PATIENT.**

FMLA/CFRA PAYROLL CODE

Hours Type Code	Hours Type Description
FY	FMLA-SICK LV- 4 HR
FQ	FMLA-SICK/FAM 4 HRS
F6	FMLA-SICK LV - FIRE-40HRS
F9	FMLA-SICK LV-FIRE 56 HR
SF	FMLA-SICK/FAM FIRE 56
FB	FMLA - OE3/O&M SICK LV BK
F4	FMLA-ANNL LV FIRE - 40 HR
F5	FMLA-ANNL LV FIRE 56 JUL
F7	FMLA-ANNL LV FIRE 56 AUG
FU	FMLA-ANNL FMGT 56 JUL
YX	FMLA-ANNL LEAVE NONEXEMPT
F2	FMLA-ANNL EXEMPT NONSAFET
FO	FMLA-ANNUAL LV - O&M 2008
YQ	FMLA-ANNL ASSTDH/MV/PP
YY	FMLA-ANNL LV OVER MAX
FC	FMLA - COMP TIME - 100%
FT	FMLA - COMP TIME - 150%
FJ	FMLA - HOLIDAY
FK	FMLA - HOLIDAY FLOATER
F0	FMLA - SCEA SPEC LEAVE
1F	FMLA - SPOA SPEC LEAVE
FD	FMLA - MGT LEAVE - POL40
FG	FMLA - FURL POL 08-09
FH	FMLA - FURL POL 09-10
FI	FMLA - FURL POL 10-11
FN	FMLA - FURL POL 11-12
PF	FMLA - FURL POL 12-13
QF	FMLA - FURL POL 13-14
FX	FMLA - FURL 62 HRS
25	FMLA LEAVE - WITHOUT PAY
FW	FMLA-WORK COMP
FZ	FMLA LEAVE - CATAS PAY
FR	FMLA LEAVE - CATAS RECEIP